

		FOR OFF USE					

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2004  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2004)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0023036</div> <div>Facility Name: Bayside Terrace</div> <div>Address: 1100 South Lewis Waukegan 60085</div> <div>County: Lake</div> <div>Telephone Number: (847) 244-8196 Fax #: (847) 244-7647</div> <div>IDPA ID Number: 362886600001</div> <div>Date of Initial License for Current Owners: 11/03/76</div> <div>Type of Ownership:</div> <div><div><div>VOLUNTARY,NON-PROFIT</div><div>Charitable Corp.</div><div>Trust</div><div>IRS Exemption Code</div></div><div><div>X PROPRIETARY</div><div>Individual</div><div>X Partnership</div><div>Corporation</div><div>"Sub-S" Corp.</div><div>Limited Liability Co.</div><div>Trust</div><div>Other</div></div><div><div>GOVERNMENTAL</div><div>State</div><div>County</div><div>Other</div></div></div> <div><div>In the event there are further questions about this report, please contact:</div><div>Name: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed)</div><div>(Print Name and Title) Robert A. Rose, C.P.A.</div><div>(Firm Name &amp; Address) Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax #: (847) 236-1155</div></div> <div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number    Bayside Terrace

#    0023036    Report Period Beginning:    01/01/04    Ending:    12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds    N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	168	Intermediate (ICF)	168	61,488	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	7

B. Census-For the entire report period.

	1 Level of Care	2                      3                      4                      5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	51,149	1,665	1,791	54,605	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,149	1,665	1,791	54,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.)    88.81%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?

56 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?    Yes

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES    ☐    NO    ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES    ☐    NO    ☒

I. On what date did you start providing long term care at this location?  
Date started    11/03/76

J. Was the facility purchased or leased after January 1, 1978?  
YES    ☐    Date                            NO    ☒

K. Was the facility certified for Medicare during the reporting year?  
YES    ☐    NO    ☒    If YES, enter number  
of beds certified                            and days of care provided                        

Medicare Intermediary    N/A

IV. ACCOUNTING BASIS

ACCRAUAL    ☒    MODIFIED  
CASH\*    ☐    CASH\*    ☐

Is your fiscal year identical to your tax year?    YES    ☒    NO    ☐

Tax Year:    12/31/04    Fiscal Year:    12/31/04

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number      Bayside Terrace      #      0023036      Report Period Beginning:      01/01/04      Ending:      12/31/04

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	250,671	26,215	7,440	284,326		284,326		284,326			1
2	Food Purchase		219,194		219,194		219,194	(67)	219,127			2
3	Housekeeping	120,174	21,905		142,079		142,079		142,079			3
4	Laundry	20,809	12,537		33,346		33,346		33,346			4
5	Heat and Other Utilities			105,745	105,745		105,745	273	106,018			5
6	Maintenance	43,706	553	75,619	119,878		119,878	(9,264)	110,614			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	435,360	280,404	188,804	904,568		904,568	(9,058)	895,510			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	856,070	74,371	55,296	985,737		985,737	(41,523)	944,214			10
10a	Therapy			683	683		683		683			10a
11	Activities	117,836	5,231		123,067		123,067		123,067			11
12	Social Services	219,161	1,906	324	221,391		221,391		221,391			12
13	Nurse Aide Training											13
14	Program Transportation			3,836	3,836		3,836		3,836			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,193,067	81,508	61,339	1,335,914		1,335,914	(41,523)	1,294,391			16
	<b>C. General Administration</b>											
17	Administrative	104,071		781,638	885,709		885,709	(701,637)	184,072			17
18	Directors Fees											18
19	Professional Services			86,056	86,056		86,056	(14,137)	71,920			19
20	Dues, Fees, Subscriptions & Promotions			30,805	30,805		30,805	(19,262)	11,543			20
21	Clerical & General Office Expenses	161,310	19,815	31,255	212,380		212,380	(15,342)	197,038			21
22	Employee Benefits & Payroll Taxes			306,506	306,506		306,506	(2,625)	303,881			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,128	21,128		21,128	(11,484)	9,644			24
25	Other Admin. Staff Transportation			571	571		571		571			25
26	Insurance-Prop.Liab.Malpractice			94,900	94,900		94,900	297	95,197			26
27	Other (specify):*							4,786	4,786			27
28	<b>TOTAL General Administration</b>	265,381	19,815	1,352,859	1,638,055		1,638,055	(759,404)	878,651			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,893,808	381,727	1,603,002	3,878,537		3,878,537	(809,984)	3,068,553			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			69,267	69,267		69,267	(1,731)	67,536			30
31	Amortization of Pre-Op. & Org.			2,709	2,709		2,709		2,709			31
32	Interest			6,569	6,569		6,569	(9,320)	(2,751)			32
33	Real Estate Taxes			94,280	94,280		94,280		94,280			33
34	Rent-Facility & Grounds							15,020	15,020			34
35	Rent-Equipment & Vehicles			8,311	8,311		8,311		8,311			35
36	Other (specify):*											36
37	TOTAL Ownership			181,136	181,136		181,136	3,969	185,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			63,734	63,734		63,734	(63,734)	(0)			41
42	Provider Participation Fee			92,232	92,232		92,232		92,232			42
43	Other (specify):*	12,173			12,173		12,173	(12,173)	0			43
44	TOTAL Special Cost Centers	12,173		155,966	168,139		168,139	(75,907)	92,232			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,905,981	381,727	1,940,104	4,227,812		4,227,812	(881,922)	3,345,890			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,386)	30		9
10	Interest and Other Investment Income	(9,320)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,835)	21		18
19	Entertainment				19
20	Contributions	(1,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,712)	21		24
25	Fund Raising, Advertising and Promotional	(14,462)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,341)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(162,007)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (209,079)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(672,843)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (672,843)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (881,922)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bayside Terrace

	ID#	0023036
Report Period Beginning:		01/01/04
Ending:		12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (63,734)	41	1
2	Veterans' Prescription Drugs	(35,559)	10	2
3	Veteran Laboratory Charges	(879)	10	3
4	Veteran Physician Charges	(5,085)	10	4
5	Marketing Director	(12,173)	43	5
6	Theft and Damage Loss	(238)	21	6
7	Capitalized Repairs & Maintenance	(9,264)	06	7
8	COPE	(3,113)	20	8
9	Prior Year Legal	(208)	19	9
10	Christmas Gifts	(111)	20	10
11	Out Of State Seminar	(11,484)	24	11
12	Non-Care Asset Depreciation	(1,775)	30	12
13	Non-Allowable Accounting Fees	(14,475)	19	13
14	Partners' Life Insurance	(3,909)	22	14
15				15
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98				98
99				99
100				100
101	Total	(162,007)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bayside Terrace # 0023036 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(67)											(67)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			273									273	5
6	Maintenance	(9,264)											(9,264)	6
7	Other (specify):*													7
8	TOTAL General Services	(9,331)		273									(9,058)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(41,523)											(41,523)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(41,523)											(41,523)	16
	C. General Administration													
17	Administrative			(39,000)	(370,837)	(291,800)							(701,637)	17
18	Directors Fees													18
19	Professional Services	(14,683)		358	94	94							(14,137)	19
20	Fees, Subscriptions & Promotions	(19,636)		374									(19,262)	20
21	Clerical & General Office Expenses	(17,126)		1,784									(15,342)	21
22	Employee Benefits & Payroll Taxes	(3,909)		1,284									(2,625)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(11,484)											(11,484)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			297									297	26
27	Other (specify):*				2,425	2,361							4,786	27
28	TOTAL General Administration	(66,838)		(34,903)	(368,318)	(289,345)							(759,404)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,691)		(34,630)	(368,318)	(289,345)							(809,984)	29



STATE OF ILLINOIS

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,161)		4,430									(1,731)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,320)											(9,320)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			15,020									15,020	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(15,481)		19,450									3,969	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(63,734)											(63,734)	41
42	Provider Participation Fee													42
43	Other (specify):*	(12,173)											(12,173)	43
44	TOTAL Special Cost Centers	(75,907)											(75,907)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(209,079)		(15,180)	(368,318)	(289,345)							(881,922)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%	\$ 273	\$ 273	15
16	V	6	REPAIRS AND MAINT.		A.H.B. D/B/A ABH MANAGEMENT	100.00%			16
17	V	19	PROFESSIONAL FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	358	358	17
18	V	20	DUES, SUBS. & FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	374	374	18
19	V	21	CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,784	1,784	19
20	V	22	EMPLOYEE BENEFITS		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,284	1,284	20
21	V	26	INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	297	297	21
22	V	30	DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	4,430	4,430	22
23	V	32	INTEREST		A.H.B. D/B/A ABH MANAGEMENT	100.00%			23
24	V	34	RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	15,020	15,020	24
25	V								25
26	V	17	HOME OFFICE	39,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%		(39,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 39,000			\$ 23,820	\$ * (15,180)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 40,000	\$ 40,000	15
16	V	19	PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	94	94	16
17	V	27	PAYROLL TAXES		HEALTH RESOURCE, INC.	100.00%	2,425	2,425	17
18	V					100.00%			18
19	V	17	MANAGEMENT FEES	410,837	HEALTH RESOURCE, INC.			(410,837)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 410,837			\$ 42,519	\$ * (368,318)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 40,000	\$ 40,000	15
16	V	19	PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	94	94	16
17	V	27	PAYROLL TAXES		KARLA BISHOP, INC.	100.00%	2,361	2,361	17
18	V								18
19	V	17	MANAGEMENT FEES	331,800	KARLA BISHOP, INC.	100.00%		(331,800)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 331,800			\$ 42,455	\$ * (289,345)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #      0023036      Report Period Beginning:      01/01/04      Ending:      12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Earl Rosenbaum	Gen. Partner	Administrative	34.11%	See Attached	10.00	25.00%	Admin. Comp	\$ 40,000	17-7	1
2	Karla Bishop	Gen. Partner	Administrative	7.45%	See Attached	10.00	25.00%	Admin. Comp	40,000	17-7	2
3	Jack Bishop	Relative	Maintenance	0.00%	None	30.00	100.00%	Maint. Sal	38,254	6-1	3
4	Pam Price	Relative	Nursing	0.00%	None	24.00	100.00%	Nur. Sal.	36,075	10-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 154,329		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      A.H.B. D/B/A ABH MANAGEMENT  
Street Address      600 CENTRAL AVENUE  
City / State / Zip Code      HIGHLAND PARK, IL. 60035  
Phone Number      ( 847)432-7262  
Fax Number      ( 847)432-6095

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	PATIENT DAYS	138,654	3	\$ 693	\$	54,605	\$ 273	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	138,654	3			54,605		2
3	19	PROFESSIONAL FEES	PATIENT DAYS	138,654	3	908		54,605	358	3
4	20	DUES, SUBS. & FEES	PATIENT DAYS	138,654	3	950		54,605	374	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	138,654	3	4,530		54,605	1,784	5
6	22	EMPLOYEE BENEFITS	PATIENT DAYS	138,654	3	3,260		54,605	1,284	6
7	26	INSURANCE	PATIENT DAYS	138,654	3	753		54,605	297	7
8	30	DEPRECIATION	PATIENT DAYS	138,654	3	11,250		54,605	4,430	8
9	32	INTEREST	PATIENT DAYS	138,654	3			54,605		9
10	34	RENT	PATIENT DAYS	138,654	3	38,139		54,605	15,020	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 60,483	\$		\$ 23,820	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      HEALTH RESOURCE, INC.  
Street Address      PO BOX 1275  
City / State / Zip Code      HIGHLAND PARK, IL. 60035  
Phone Number      ( 847)432-7262  
Fax Number      ( 847)432-6095

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMIN-E. ROSENBAUM	AVG. HOURS WKD	40	3	160,000	160,000	10	40,000	1
2	19	ADM. COMP.- IVY FISHMAN	AVG. HOURS WKD	40	3	375		10	94	2
3	27	ADM. COMP.- A. ROSENBAUM	AVG. HOURS WKD	40	3	9,699		10	2,425	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 170,074	\$ 160,000		\$ 42,519	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      KARLA BISHOP, INC.  
Street Address      271 RIVERS DRIVE  
City / State / Zip Code      LAKE BLUFF, IL 60044  
Phone Number      ( 847)432-7262  
Fax Number      ( 847)432-6095

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WKS	40	3	\$ 160,000	\$ 160,000	10	\$ 40,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WKS	40	3	375		10	94	2
3	27	PAYROLL TAXES	AVG. HOURS WKS	40	3	9,445		10	2,361	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 169,820	\$ 160,000		\$ 42,455	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office  
or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office  
or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Bayside Terrace      #    0023036    Report Period Beginning:      01/01/04      Ending:    12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2	American National		X	Industrial Revenue Bond	Variable	6/9/96	488,602	35,638	10/15/05		1,893	2
3	American National		X	Fixed Assets		1/31/01	125,000	28,485	1/31/06		2,932	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank One		X	Line Of Credit			230,000	60,000			1,744	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						\$ 843,602	\$ 124,123			\$ 6,569	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,192)	10
11	Dividend		X								(128)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			\$ (9,320)	14
15	TOTALS (line 9+line14)						\$ 843,602	\$ 124,123			\$ (2,751)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.				\$	97,000    1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	94,680    2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,320)    3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	96,600    4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$	6
TOTAL REFUND \$                      For                      Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	94,280    7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	67,019	8	
		2000	69,543	9	
		2001	82,198	10	
		2002	92,386	11	
		2003	94,680	12	
				13	FOR OHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2003    \$    13
				14	PLUS APPEAL COST FROM LINE 5    \$    14
				15	LESS REFUND FROM LINE 6    \$    15
				16	AMOUNT TO USE FOR RATE CALCULATION \$    16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bayside Terrace COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0023036

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>08-32-107-012</u>	<u>Long Term Care Facility</u>	\$ <u>94,679.89</u>	\$ <u>94,679.89</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>94,679.89</u>	\$ <u>94,679.89</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

## 2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Bayside Terrace</u>	COUNTY	<u>Lake</u>
---------------	------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0023036

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

### A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

## B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

### C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,360

B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 51,508

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 2,709

4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>104,671</u>	<u>1976</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	104,671		\$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

11/2/2005 3:18 PM

Facility Name &amp; ID Number    Bayside Terrace

#    0023036

Report Period Beginning:

01/01/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119			1976	\$ 1,082,366	\$		\$	\$	108,236	4
5	49			1986	630,167			18,005	18,005	336,120	5
6				1986	43,252			1,236	1,236	23,072	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1977	1,498		20	-		1,498	9
10	Various			1978	7,531		20	-		7,531	10
11	Various			1979	14,356		20	-		14,356	11
12	Various			1980	4,020		20	-		4,016	12
13	Various			1981	11,197		20	-		11,155	13
14	Various			1982	16,226		20	-		16,226	14
15	Various			1983	17,495		20	-		16,783	15
16	Various			1984	15,752		20	-		15,520	16
17	Various			1985	11,170		20	85	85	11,114	17
18	Various			1986	17,867		20	868	868	17,400	18
19	Various			1987	22,247		20	1,171	1,171	20,262	19
20	Various			1988	21,019		20	1,107	1,107	18,157	20
21	Various			1989	26,162		20	1,308	1,308	19,838	21
22	Various			1990	9,005		20	450	450	6,542	22
23	Various			1991	47,502		20	2,374	2,374	31,305	23
24	Various			1992	13,226		20	564	564	9,011	24
25	Various			1993	39,155		20	1,958	1,958	22,329	25
26	Various			1994	11,363		20	568	568	5,783	26
27	Various			1995	3,826		20	191	191	1,825	27
28	Various			1996	53,988		20	2,700	2,700	23,567	28
29	Various			1997	15,489		20	776	776	5,796	29
30	Various			1998	13,280		20	665	665	3,417	30
31	Various			1999	52,464		20	2,214	2,214	20,226	31
32	Various			2000	19,525		20	977	977	3,906	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		3,554	73		372	299	820	68
69	Financial Statement Depreciation			67,492			(67,492)		69
70	TOTAL (lines 4 thru 69)		\$ 2,224,702	\$ 67,565		\$ 37,589	\$ (29,976)	\$ 775,811	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number    Bayside Terrace

#    0023036

Report Period Beginning:

01/01/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,224,702	\$ 67,565		\$ 37,589	\$ (29,976)	\$ 775,811	1
2	Ceramic Tile	2001	36,022		20	1,801	1,801	7,204	2
3	Ceramic Tile	2001	7,861		20	393	393	1,441	3
4	Wallcovering	2001	11,631		20	582	582	1,794	4
5	Glass Frame	2001	529		20	26	26	81	5
6	Drywall Work	2001	450		20	23	23	70	6
7	Roof Repairs	2001	525		20	26	26	81	7
8	Wall Guards	2001	804		20	40	40	124	8
9	Vinyl Wallcover	2001	1,397		20	70	70	216	9
10	Coil Replacement	2001	850		20	43	43	132	10
11	Asphalt Rep	2001	3,400		20	170	170	524	11
12	Gutter Repl	2001	2,250		20	113	113	347	12
13	Sprinkler	2001	1,225		20	61	61	189	13
14	Door Repairs	2001	752		20	38	38	116	14
15	Motor Repairs	2001	650		20	65	65	200	15
16	Wallcovering	2001	773		20	39	39	119	16
17	Vent Work	2001	522		20	26	26	80	17
18	Door Repairs	2001	575		20	29	29	88	18
19	Kitchen Cabinetry	2002	3,467		20	231	231	693	19
20	Hollow Metal Door	2002	1,339		20	67	67	162	20
21	Heating Repairs	2002	514		20	51	51	137	21
22	Water Heater Repairs	2002	621		20	62	62	160	22
23	Ac Repairs	2002	738		20	74	74	185	23
24	Ac Motor Repairs	2002	676		20	68	68	169	24
25	Rooftop Motor	2002	512		20	51	51	128	25
26	Ac Repairs	2002	876		20	125	125	302	26
27	Exhaust Fan Repairs	2002	903		20	90	90	218	27
28	Smoke Detectors	2002	503		20	50	50	122	28
29	Water Heater Repairs	2002	796		20	80	80	199	29
30	Circuit Board Repairs	2002	1,075		20	108	108	260	30
31	Resident Room Painting	2002	2,900		20	290	290	604	31
32	Fan And Curb Adapter	2002	830		20	83	83	187	32
33	Gas Valve Repairs	2002	651		20	65	65	141	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,311,319	\$ 67,565		\$ 42,629	\$ (24,936)	\$ 792,284	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number    Bayside Terrace

#    0023036

Report Period Beginning:

01/01/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,311,319	\$ 67,565		\$ 42,629	\$ (24,936)	\$ 792,284	1
2	Water Heater	2003	1,067		20	89	89	141	2
3	Condensing Unit	2003	3,048		20	254	254	339	3
4	Painting	2003	3,600		20	345	345	345	4
5	Fire Alarm Installation	2003	691		20	60	60	60	5
6	Water Meter Repairs	2003	770		20	67	67	67	6
7	Drywall Repairs	2003	500		20	44	44	44	7
8	Wall Repairs / Painting	2003	1,000		20	79	79	79	8
9	Wall Repairs	2003	500		20	35	35	35	9
10	Ceiling Repairs	2003	500		20	33	33	33	10
11	Walk-In Freezer Repairs	2003	898		20	56	56	56	11
12	Water Heater	2004	5,700		20	1,045	1,045	1,045	12
13	Smoke Detectors And Panel	2004	3,823		20	91	91	91	13
14	Furnace Repairs	2004	546		20	20	20	20	14
15	Icemaker, Delivery + Water Supply	2004	500		20	15	15	15	15
16	Fire Alarm System Repair	2004	958		20	28	28	28	16
17	Shower Repair	2004	606		20	13	13	13	17
18	Floor Maintenance	2004	1,368		20	29	29	29	18
19	Blacktop And Stripe Parking Lot	2004	3,000		20	38	38	38	19
20	Exit Light Install & Electric Work	2004	781		20	10	10	10	20
21	Furnace Circuit Board & Maintenance	2004	630		20	3	3	3	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,805	\$ 67,565		\$ 44,983	\$ (22,582)	\$ 794,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alloated - AHB			2002	3,354	73	39	332	259	743	9
10	Allocated - ABH			2003	200	-		40	40	77	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		3,554	73		372	299	820	

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 312,603	\$ 282	\$ 21,775	\$ 21,493	10	\$ 224,256	71
72	Current Year Purchases	8,137	4,075	778	(3,297)	10	778	72
73	Fully Depreciated Assets	300,870				10	300,870	73
74								74
75	TOTALS	\$ 621,610	\$ 4,357	\$ 22,553	\$ 18,196		\$ 525,904	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		1998 LEXUS	1998	\$ 25,000	\$	\$	\$	5	\$
77		1990 DODGE VAN	1990	21,434				5	21,434
78									
79									
80	TOTALS			\$ 46,434	\$	\$	\$		\$ 21,434

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 3,109,849
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 71,922
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 67,536
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (4,386)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 1,342,113

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1998 LEXUS - 1998	\$ 40,529	\$ 1,775	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 40,529	\$ 1,775	\$	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated From AHB				15,020			5
6								6
7	TOTAL				\$ 15,020			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 8,311
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):    See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT



This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 150,705	\$	1
2	Cash-Patient Deposits	37,348		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	799,552		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	164,726		5
6	Prepaid Insurance	78,050		6
7	Other Prepaid Expenses	5,424		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	36,829		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,272,634	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,210,148		15
16	Equipment, at Historical Cost	681,091		16
17	Accumulated Depreciation (book methods)	(2,584,345)		17
18	Deferred Charges	2,368		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 409,262	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,681,896	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 184,061	\$	26
27	Officer's Accounts Payable	4,238		27
28	Accounts Payable-Patient Deposits	49,891		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,696		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,216		31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 367,702	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	124,123		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 124,123	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 491,825	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,190,071	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,681,896	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,094,700	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,094,700	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	220,371	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(125,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 95,371	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,190,071	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bayside Terrace# 0023036Report Period Beginning: 01/01/04Ending: 12/31/04

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,357,859	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,357,859	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	80,737	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 80,737	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	9,320	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,320	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	267	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 267	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,448,183	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	904,568	31
32	Health Care	1,335,914	32
33	General Administration	1,638,055	33
	<b>B. Capital Expense</b>		
34	Ownership	181,136	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	75,907	35
36	Provider Participation Fee	92,232	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,227,812	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	220,371	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 220,371	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,118	2,201	\$ 75,679	\$ 34.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,622	4,841	69,663	14.39	3
4	Licensed Practical Nurses	14,146	16,617	335,497	20.19	4
5	Nurse Aides & Orderlies	40,354	43,990	375,231	8.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,841	9,675	117,836	12.18	10
11	Social Service Workers	13,273	14,334	219,161	15.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,107	23,715	250,671	10.57	15
16	Dishwashers					16
17	Maintenance Workers	1,307	1,713	43,706	25.52	17
18	Housekeepers	10,067	11,445	120,174	10.50	18
19	Laundry	1,968	2,228	20,809	9.34	19
20	Administrator	2,110	2,281	104,071	45.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,922	13,764	161,310	11.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,107	2,345	12,173	5.19	33
34	TOTAL (lines 1 - 33)	134,942	149,148	\$ 1,905,981 *	\$ 12.78	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 7,440	01-03	35
36	Medical Director	Monthly	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,500	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	683	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	324	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,147		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,270	\$ 50,796	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,270	\$ 50,796		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Dementrea Rafael	Administrator	0	\$ 104,071
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,071
B. Administrative - Other			
Description			Amount
ABH - Home Office Fees		\$	39,000
Karla Bishop, Inc.			331,800
Health Resource Inc.			410,837
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 781,637
C. Professional Services			
Vendor/Payee	Type		Amount
Frost, Ruttenberg & Rothblatt	Accounting Fees	\$	68,645
Alpha Data Service	Data Processing		2,877
Jane Osa	Pension Admin Fee		1,948
Omnicare	Computer Services		2,880
Sachnoff & Weaver	Legal Fees		9,706
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 86,057
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	33,725
Unemployment Compensation Insurance			11,420
FICA Taxes			141,732
Employee Health Insurance			99,241
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Benefits			1,356
Holiday Expense			854
Union Pension Contribution			13,961
Allocated From AHB			1,284
Employee Meals			307
TOTAL (agree to Schedule V, line 22, col.8)			\$ 303,880
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	200
Advertising: Employee Recruitment			1,628
Health Care Worker Background Check (Indicate # of checks performed 20 )			220
IL Council Of LTC			7,394
Licenses & Fees			915
Dues, Fees & Subscriptions			814
Allocated From AHB			374
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 11,544
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			9,644
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	9,644

**\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council Of LTC \$10,506.54
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$                      Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement?            YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES            NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 92,232  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$                      Has any meal income been offset against related costs?                      Indicate the amount. \$
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14

d. Have vehicle usage logs been maintained? Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.